Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALBERT BRYAN SPIRES, MD
3100 TIMMONS LANE STE 250
DALLAS TX 75374

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-0615-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY TOTAL AMOUNT DUE EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SENT"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Dispute notice was sent on November 03, 2010. No response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 05, 2010	99456-W5-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 03, 2010
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated October 01, 2010
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Has the Designated Doctor Examination (DDE) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement under 28 Texas Administrative Code §134.204?

Findings

1. According to the explanation of benefits dated October 01, 2010, the carrier reduced the medical bill because "45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY). There is no network noted on the EOB. A signed acknowledgement indicates that the respondent, Indemnity Insurance Co of North America was notified of the fee dispute on November 3, 2010. Indemnity Insurance Co of North America did not respond to the requestor's dispute. Because the respondent did not clarify or otherwise address the 45 claim adjustment code upon receipt of the request for dispute resolution, the division finds that the 45 claim adjustment code is not supported. For that reason, the dispute will be reviewed in accordance with 28 Texas Administrative Code §134.204.
2. The provider billed the amount of $950.00 for CPT code 99456-W5-WP for DDE for Maximum Medical Improvement/Impairment Rating (MMI/IR) as a Designated Doctor (DD). Documentation supports that the MMI determination is payable at $350.00. For the IR, methods of calculating IR and the number of body areas determine reimbursement. Review of the documentation supports that MMI was assigned and three body areas were rated. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on lumbar spinal region is $150.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on bilateral knee (lower extremities) is $300.00. Per 28 Texas Administrative Code §134.204(j)(4)(D)(v), the MAR for an IR using DRE on a non-musculoskeletal rib contusion is $150.00.
3. The combined MAR for the MMI/IR services rendered is $950.00. The Respondent paid $800.00 for the MMI/IR. The Requestor is due a recommended reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 07, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.